Issues Raised by the Empire Conversion

DANIEL SISTO*

At the Margaret E. Mahoney Symposium, many noted that conversions of nonprofit organizations across the country are underway, transforming billions of dollars of assets from public to private purposes, and now it has come to New York. These are critically important transformations—rather like the Oklahoma land rush or the Homestead Act—that transform the health-care delivery system as well. What are the implications for New York? As a member for 8 years of the Special Advisory Review Panel, under the chairmanship of Mr. Barba, I have had two perspectives. When I started, I was worried that Empire Blue Cross might go under and feared the effect that it would have on subscribers and hospitals. Now, as a member of the panel, I see it doing well, earning millions, and getting stronger; and now I fear that it will succeed and exact even greater double-digit discounts from the members of the Healthcare Association of New York State. Nevertheless, as a member of the panel, I think that Mr. Barba summed it up very well when he said, "When these nine come together for whatever modest role we play, people really do try to figure out what is best from a public point of view as well."

Concerns

I am anxious about the notion that the marketplace will be the proper determiner of the valuation of the charitable assets. The market can seem to be irrational: an initial public offering comes out and the next day it is up 60%; some missed an opportunity,

* Daniel Sisto is President, Healthcare Association of New York State, 74 North Pearl Street, Albany, NY 12207.

others gained one. That is not to say that market valuation is wrong, but the panel has to consider first establishing an initial base level to provide a frame of reference. How we value it, how the foundation is governed, what its purposes are—these should be thought through carefully.

Perhaps the most important issue is that not just one, but several, state insurers are undergoing this transformation. It is possible that some day nonprofit hospitals may be converted in New York State. What happens with Empire is critical because it could be a public policy precedent for what happens if and when the State must face proposed transformations of its hospital systems.

Other presenters at the symposium reported scandals: the Ohio scandal, in which executives were accused of private inurement as a result of trying to turn the Blues plan over to Columbia, and the initial New Jersey reactions when Blue Cross representatives devised a way to convert without delivering anything back to the public. Scandals in the hospital industry make those pale in comparison. Massive hospital systems have been transformed from nonprofit purposes to private purposes and have been taken over by large for-profit chains. This is not to say that the chains are venal, but that the transformation processes in many states raise huge questions about who gained from it. How do key physicians and certain board members suddenly secure private benefits without public discourse? Today, state legislatures across the country are being flooded with legislation to protect the public interest in these transformations.

Another implication is that, as Mr.Tallon reported, we are beginning to unbundle social contracts by spreading social responsibility. An example is spreading the risk of open enrollment across all insurers. We are unbundling social contracts, however, without determining what will take their place, and, in effect, we are assuming that someone will fill the void. Empire's history is as community-oriented as that of New York's hospitals. In such transformations, who will fill the void?

If the charitable asset is not adequate, society will be short-

changed. Pressures will mount dramatically in the coming years. As examples, we learned recently that the Office of Management and Budget in Washington has estimated that, due to welfare reforms, the effect of the lack of Medicaid eligibility for legal immigrants could amount to 950 million dollars for New York State. The Governor and others are fighting this provision, but at the moment there is a risk from unbundling this social contract. Who will fill that void?

Also, with the unbundling of the regulatory system, everybody is negotiating and there will be large hospital discounts, which will force service cuts. Meanwhile, we have between 2.5 and 2.9 million uninsured people in New York State. We still face social pathologies such as AIDS, tuberculosis, and violence. As nonprofit entities transform into for-profits, we need new conceptual designs to fulfill the old social contract.

Models for Fulfilling the Social Need

One model that might be considered is the blending of insurance and health-provider functions. An example from another industry illustrates the model. Ten years ago, one might deposit a paycheck into a checking account, go to a Savings and Loan to pay the mortgage, stop at a brokerage office to invest in a mutual fund, and then go home. Today, one might go to the brokerage office and pay the mortgage with a check from a money market account, and then stop at the bank and invest in its mutual fund. What used to be called brokerage houses and what used to be called banks have merged into a new amalgam. The same is true in telecommunications, with cable companies and television broadcasting. A blending of institutions is creating new product lines. The same is happening in health-care delivery, as providers and insurers meld together. It is gratifying that, in a few experiments, Empire and other insurers have found a way to craft partnerships with the old acute-care hospitals that enable both organizations to become shared risk takers for the health of the community. That is a beginning, and legislation passed last year will allow many of New

York's traditional hospitals to become provider-sponsored networks, or integrated delivery systems, as they are called in New York.

I believe that the same argument applies to keeping our system nonprofit on the provider side. Columbia/HCA and Tenet are not venal and we virtuous, but enormous savings can be achieved by transforming our hospital system and our health-care delivery system. Savings will result from aligning financial incentives between insurers and providers, whether in partnership or by having providers become, in effect, risk-taking, integrated delivery systems. When that is done there is a built-in incentive to keep a community healthy.

The future lies not in negating the quality or the cost effectiveness of proprietary-based hospital systems, but in emulating them. We should imitate them by becoming businesslike but not business-driven. In the next generation we should resolve to take the same social contracts and the same sense of mission, and link them in partnerships with insurers. As providers, we should take on risk and focus on maintaining the health of the community. The debate in the next few years will ask whether we did this correctly with Empire. Did we set up the charitable asset correctly? Is it serving the social purpose? More broadly, how can we transform the rest of the industry so that the social contracts of the past are not abandoned? The answer lies partly in transforming the hospital system into integrated delivery networks focused on community health.